A CASE OF CURED ANEURISM OF THE ABDOMINAL AORTA SIMULATING A SOLID TUMOR.[1]

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SURGICAL diseases within the abdomen are more difficult to diagnosticate than in any other portion of the body except within the cranium. As my experience increases I am more and more convinced of the fact that one can comparatively rarely make a correct diagnosis of an intra-abdominal lesion without an exploratory operation. In these cases I am seldom satisfied to form an opinion on which to act until I have examined the case under an anæsthetic. This is a rule which should be followed: When the surgeon can reasonably expect to find a condition which will require operative treatment, the final and determining examination should be made with the patient under ether and prepared for operation, and if this examination indicates the necessity for an operation it can be proceeded with at once, thus avoiding the shock of a second etherization. These remarks are applicable to all surgical diseases within the abdomen, but particularly to tumors. Many diseases, appendicitis for instance, give sufficient symptoms, subjective and objective, to lead to a pretty accurate knowledge of the condition causing them, but a slowly developing tumor generally gives no symptoms which can aid very materially in determining its exact nature and origin. The only symptoms of a tumor originating in one organ may be those produced by its pressure on another organ, and thus one may be entirely misled as to its origin.

I feel inclined, as a rule, to consider my laparotomies as exploratory operations. Too often is it the case that an operator will start with a definite plan of operation, having a positive, though

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generally mistaken, opinion as to the condition he has to treat; not finding the condition he expected does not always deter him from proceding as he had planned to. This is most noticeable in the treatment of diseases of the ovaries and their tubes. Were the operator proceeding with the idea that he would find out the nature of the trouble after he had opened the abdomen, and then decide upon a plan of treatment, his judgment would be much freer than if he had to overcome a preconceived and proclaimed opinion.

I will subjoin the history of a case of abdominal tumor which illustrates the difficulty of making a correct diagnosis of diseases in this region.

The patient, a man fifty-one years of age, was admitted to the medical side of the colored hospital on July 20, 1891. He had been fairly well until about ten months previous to this date, when the present trouble began. He had had several of the ordinary diseases of childhood, also inflammatory rheumatism and diphtheria. He denied having had syphilis, and no evidence of it could be found when admitted to the hospital. He had suffered for about ten months from a pretty severe lumbar pain and from constant dyspepsia. He was considerably emaciated, had a badly-coated tongue. His pulse was about 100 and his temperature was slightly elevated.

The patient was at first under the care of an attending physician who was about ending his term of service; he was shortly succeeded by his alternate. On examination this first physician found a tumor in the upper part of the umbilical region. He found it to have a distinct expanding pulsation and a bruit with the first sound of the heart. He made a diagnosis of aneurism of the abdominal aorta. The physician who succeeded the first attending a few weeks after the patient's admission to the hospital, decided that the tumor was not an aneurism. He found the pulsations in the tumor were not distinctly expanding and that the aorta could be felt pulsating independently from it, apparently below and to the left.

I saw the patient on January 5, 1892. His appearance and pulse suggested marasmus. The tumor could be felt very readily, and it could be made out that it was a rounded, elongated mass, extending well forward. The free end was quite superficial. The attached end seemed broader, and extended deep down into the lower part of the

epigastrium. It pulsated with the aorta; there was an indistinct sensation of expanding to it; a loud bruit could be heard, especially to the left. My impression was that it was a cyst resting on the aorta, and judging from the digestive disturbance and the patient's emaciation, I thought it might be a cyst of the pancreas. The urine and fæces were examined for pancreatic disease with negative results. I advised an exploratory laparotomy. This was done on January 9. The abdomen was opened in the median line, and the superficial end of the tumor was readily found. The tumor was intimately attached to the omentum, and the intestines by firm, dense adhesions. These adhesions were separated with great difficulty.

The tumor was but partly freed, as it did not seem safe to proceed further on account of the amount and the density of the adhesions. The tumor was long and tapering a little to the superficial end. It was very elastic, and presented all the appearance of a tense, thick wall cyst. It could be followed down the pancreas, which could be felt to be firmly attached to it. The base of the tumor rested firmly on the aorta, and, of course, pulsated forcibly with it. I was almost as uncertain of my diagnosis now as before, but I was still inclined to think it was a cyst of the pancreas, whose wall was rendered markedly thick by the layers of organized lymph. I partly closed the abdominal wall, leaving the end of the tumor in the wound held by sutures, intending to explore its interior after the abdominal cavity had been shut off by adhesions to the tumor. The patient left the operating room in fair condition, and I was greatly surprised to hear that he had died six hours after the operation. The cause of death was shock.

An autopsy was made and confirmed the conditions found at the operation.

The tumor was firmly attached to the pancreas, which was unfortunately torn off and not removed with the tumor. It was further found that it was a sacculated aneurism of the aorta. Unfortunately, the aorta was cut close to the aneurism, and none of its branches were preserved, so that it was difficult, when I saw the specimen, to determine the exact location. I think it was just below the superior mesenteric artery. The tumor weighed about a pound. It was filled with solid laminated fibrin, and was a cured aneurism, at least temporarily.

I have reported this case because it is one of a good deal of

interest, and is a unique one. It is certainly very remarkable to find an aneurism of a vessel of this size in which coagulation has taken place. The orifice to this sac was large, and the force of the blood current at this point is very great. Undoubtedly the cure was effected by the manipulations of repeated examinations, aided by rest in bed.

This case was at first an easy one to diagnose, and had the first physician continued in attendance he would doubtless have recognized the true state of affairs when the change took place. Later, the characteristics of aneurism were wanting, and the symptoms pointed entirely to disease of the digestive tract; and the situation of the tumor rendered it probable that the pancreas was the organ involved.